MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (63)

01532

CERTIFICATE OF DEATH

Reg. Dist. No. 63

1. PLACE OF DEATH:

County: Caroline

City or town: Preston - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, Institution, or street address where death occurred: Near Harmony

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Caroline

City or town: Preston - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Near Harmony

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Sadie E. Biscoe

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: W. Dudley Biscoe

6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): June 5, 1880

8. AGE:

Years	Months	Days	If less than one day
64	7	28	...hrs. ...min.

9. Birthplace: Kent County, Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER

12. Name: James Frazier

13. Birthplace: Talbot County, Maryland

MOTHER

14. Maiden name: Sarah —

15. Birthplace: Talbot County, Maryland

16. Informant: W. Dudley Biscoe

Address: Preston, Maryland, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: February 7 1945 (month) (day) (year)

Cemetery or crematory: Linchester Cemetery

Location: Preston, Maryland

18. Funeral director: J. J. Frampton and Son

Address: Federalsburg, Maryland

19. 2/7 (Date rec'd by registrar) 1945 C. D. Plummer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 3 1945, at 10:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3 1945 to Feb 3 1945 and that I last saw h... alive on Feb 3 1945

Immediate cause of death	DURATION
Cardiac - Auricular Fibrillation	3 weeks.
Due to: Hypertension	Probably 4 or 5 years
Due to:	
Other conditions: Bronchial Pneumonia	4 days.

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Paul Dunton M D (M. D. or other)

Address: Denton Md Date signed: Feb 6 - 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186)

CERTIFICATE OF DEATH

01533

Reg. Dist. No. 60

1. PLACE OF DEATH:
County: Caroline
City or town: Goldsboro · Rural ·
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Caroline
City or town: Goldsboro · Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ida. R. Cahall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed.

6.(b) Name of husband or wife: Walter Cahall.
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Nov. 6, 1864

8. AGE: Years	Months	Days	If less than one day
80	2	27	hrs. min.

9. Birthplace: Templeville Caroline Md.
(Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business
FATHER 12. Name: Richard Teagar
13. Birthplace: Md.
MOTHER 14. Maiden name: Marian Fitzgerald.
15. Birthplace: Md.
16. Informant: John Cahall
Address: Goldsboro Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 6. 1945. (month) (day) (year)
Cemetery or crematory: Templeville
Location: Templeville Md.
18. Funeral director: Raymond B. Rawlings
Address: Greensboro Md.
19. 2/4/45 (Date rec'd by registrar) 19 A C Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 2 19 45 at 12.30 A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 15 19 45 to Feb 2 19 45
and that I last saw her alive on February 1 19 45

	DURATION
Immediate cause of death: Chronic Nephritis	
Due to: Arterio Sclerosis	
Cardiovascular Disease	
Due to:	
Other conditions: Fracture Neck of Femur	6 da.
Accidental Fall—Fell from bed. C.M.S.R.	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident. Date of: January 27. 1945.
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Bed Room
Means of injury: Fell from bed. Injured at work?

23. SIGNATURE: C H Stevenson M D
M. D. or other
Address: Greensboro Md Date signed: 2/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

MARGIN RESERVED FOR BINDING (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

01534

CERTIFICATE OF DEATH

Reg. Dist. No. 62

1. PLACE OF DEATH:
County: Caroline
City or town: near Denton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Caroline
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Ella Powell Carroll

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	married

6.(b) Name of husband or wife: Carsine Carroll
6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Dec. 25th 1870

8. AGE: Years: 74 | Months: 1 | Days: 12 | If less than one day: hrs. min.

9. Birthplace: Williston, Queen Anne's
(Town, county, and state)

10. Usual occupation: at home

11. Industry or business:

FATHER
12. Name: Samuel Powell
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Mary E. Heath
15. Birthplace: Maryland

16. Informant: Wellington Ivey Powell
Address: Denton

17. Buried (Burial, cremation, or removal. Which?) Date thereof 2-10-45 (month) (day) (year)
Cemetery or crematory: Denton Cemetery
Location: Denton, Md.

18. Funeral director: J. Virgil Sewell
Address: Denton, Md.

19. 2-10 1945 (Date rec'd by registrar) Mrs O Jump Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7th 1945 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944, to Feb 7 1945 and that I last saw h[illegible] alive on Feb 5 1945

Immediate cause of death	DURATION
Chronic Myocarditis	5 yrs.
Due to Arteriosclerosis	10 yrs.
Due to Chronic Nephritis	12 yrs.
Other conditions	

(Includs pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Kind of injury: Injured at work?

23. SIGNATURE: Amron D Teague M. D. or other
Address: Denton Date signed: 2/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-2)

01535

CERTIFICATE OF DEATH

Reg. Diat. No. 61

1. PLACE OF DEATH:
County: Caroline
City or town: Greensboro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Caroline
City or town: Greensboro
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME James A. Clough

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Ada Thorpe Clough
6.(c) If alive, give age: 56 years
7. Birth date of deceased (mo., day, yr.): Oct. 26. 1889

8. AGE:

Years	Months	Days	If less than one day
55	3	17	hrs. min.

9. Birthplace: Englewide Queen Anne Md.
(Town, county and state)
10. Usual occupation: Housewife.
11. Industry or business: ✓

MOTHER
12. Name: Charlie Clough
13. Birthplace: Md.

FATHER
14. Maiden name: Augie Downs.
15. Birthplace: Md.

16. Informant: Ada Clough
Address: Greensboro Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 16. 1945. (month) (day) (year)
Cemetery or crematory: Greensboro
Location: Greensboro Md
18. Funeral director: Raymond B. Rawlings
Address: Greensboro Md.

19. Feb 14 1945 L. M. L. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 17 19 45, at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 1943, to Feb. 12 1945 and that I last saw him alive on February 12 1945

Immediate cause of death	DURATION
Progressive Cerebral Sclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Charles H. Townsend M.D.
M. D. or other
Address: Greensboro Md. Date signed: Feb. 14 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

01536

Reg. Diat. No. 63

1. PLACE OF DEATH:

County Caroline

City or town Preston

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, Institution, or street address where death occurred:

Near Mt. Pleasant Church

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline

City or town Preston - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Mt. Pleasant Church

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME William E. Foster

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife Arzella Foster

6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) August 15, 1864

8. AGE:	Years	Months	Days	If less than one day
	80	6	6	...hrs. ...min.

9. Birthplace Talbot County, Maryland (Town, county, and state)

10. Usual occupation Farm laborer

11. Industry or business Farm

FATHER 12. Name John Foster

FATHER 13. Birthplace Talbot County, Maryland

MOTHER 14. Maiden name Julia Ann Lake

MOTHER 15. Birthplace Talbot County, Maryland

16. Informant Mrs. Arzella Foster

Address Preston, Maryland, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof February 25 1945 (month) (day) (year)

Cemetery or crematory Mt. Pleasant Cemetery

Location Near Preston, Maryland

18. Funeral director J. J. Frampton and Son

Address Federalsburg, Maryland

19. February 21 1945 (Date rec'd by registrar) C. W. Plummer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 21 1945, at 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 14 1944 to February 21 1945

and that I last saw h... alive on February 2 1945

Immediate cause of death Cerebral Hemorrhage — DURATION 5 days

Due to Arteriosclerosis C — ?

Hypertension

Due to —

Other conditions Benign Prostatic Hypertrophy — 10 years

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE [signature] M. D. or other

Address [illegible] Date signed 2-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

CERTIFICATE OF DEATH

01537

Reg. Diat. No. 64

1. PLACE OF DEATH:

County Caroline

City or town Federalsburg - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

Near American Corner

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Caroline

City or town Federalsburg - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Near American Corner

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lester Thomas Haynes

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife —

B.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) February 23, 1945

8. AGE:

Years	Months	Days	If less than one day
—	—	—	11 hrs. ... min.

9. Birthplace Federalsburg Maryland R.F.D.

(Town, county, and state)

10. Usual occupation Infant

11. Industry or business —

FATHER

12. Name Francis L. Haynes

13. Birthplace Caroline County, Maryland

MOTHER

14. Maiden name Gladys Mapp

15. Birthplace Virginia

16. Informant Francis L. Haynes

Address Federalsburg, Maryland R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof February 24 1945 (month) (day) (year)

Cemetery or crematory Federal Hill Cemetery

Location Federalsburg Maryland

18. Funeral director J. J. Frampton and Son

Address Federalsburg, Maryland

19. February 24 1945 (Date rec'd by registrar) J. J. Frampton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23 1945, at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 23 1945 to Feb 23 1945

and that I last saw h.i.m. alive on Feb 23 1945

Immediate cause of death	DURATION
Prematurity	
Due to 6 months.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank M Anderson M. D. or other

Address Federalsburg Md. Date signed 2/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-a

01538

CERTIFICATE OF DEATH

Reg. Diat. No. 62

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Caroline

City or town Denton, Md. R 3 D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? full life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME India M. Todd

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	white	widowed

6.(b) Name of husband or wife Edgar Todd deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 8, 1872

8. AGE:	Years	Months	Days	If less than one day
	72	11	19	hrs. min.

9. Birthplace Denton, Md. - R 3 D (Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name Wm. E. Hubbard

13. Birthplace Md.

MOTHER 14. Maiden name Sarah A. Wright

15. Birthplace Md.

19. Informant Alva Hubbard

Address Denton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-1-1945 (month) (day) (year)

Cemetery or crematory Concord Cemetery

Location Concord, Md.

19. Funeral director Harvey W. Ellingsworth

Address Federalsburg, Md.

19. 2-28 1945 (Date rec'd by registrar) D. A. Geo. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1945, at 12 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to Feb. 27 1945 and that I last saw her alive on Feb. 27 1945

Immediate cause of death	DURATION
Due to Cardio-Vascular-Renal disease	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroal causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE Dawson D George M. D. or other

Address Denton Date signed 3/28/45

01539

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 60

1. PLACE OF DEATH:
County: Caroline
City or town: Marydel Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Caroline
City or town: Marydel Md Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sarah A. Wilkerson
3.(b) Social Security Number

4. Sex: F.
5. Color or race: B
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: James Wilkerson
6.(c) If alive, give age 69 years
7. Birth date of deceased (mo., day, yr.): Nov. 4, ~~1877~~ 1877

8. AGE: Years 67 | Months 3 | Days 11 | If less than one day ... hrs. ... min.

9. Birthplace: Marydel Caroline Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Sam Kelson
13. Birthplace: Md

MOTHER
14. Maiden name: Amanda Johnson
15. Birthplace: Md

16. Informant: James Wilkerson
Address: Marydel Md

17. Burial Date thereof 2/22/45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Mt Zion
Location: Marydel Md
18. Funeral director: Raymond B. Rawlings
Address: Greensboro Md
19. 2/20/45 A C Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 18 1945, at 4.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 29, 1944, to Feb 18, 1945
and that I last saw her alive on ... 19...

	DURATION
Immediate cause of death: Chronic Nephritis	5 yrs.
Due to: Arteriosclerotic Cardiovascular Disease	10 yrs
Due to	
Other conditions: Gangrenous Ulcer of leg	1 yr

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur?
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Charles H. Stonecypher M.D. M. D. or other
Address: Greensboro Md Date signed: Feb 20 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15